


HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE					
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION ( <i>Sign each entry</i> )						
	<b>Family Practice Clinic</b>		<b>31 MDG</b>		<b>Aviano AB, Italy</b>		
Date _____	<b>S:</b> ____y/o female > <b>13YO</b> c/o abnormal <b>VAGINAL DISCHARGE</b> for ____ days.  <b>O: General</b> Vulva: Normal Erythema Edema Atrophic Excoriated BUS: Normal (without discharge or lesion) Discharge Bartholin Cyst Vagina: Normal Rugated Atrophic Discharge Cervix: Normal Friable Discharge Cervical motion tenderness Uterus: NSSC Nontender Mobile Tender Adnexa: Normal Absent Tender Masses Thickened  <b>Lab:</b> KOH: fungal elements whiff test Wet Prep: pH _____ Clue cells trichomonas Bacteria WBC  <b>A:</b> Bacterial Vaginosis Moniliasis Trichomoniasis other _____  <b>P:</b> 1) Chlamydia GC RPR HIV Hep B 2) Written instructions given and discussed with patient  <b>P:</b>						
Time _____							
HCP _____							
T _____							
Tob Y/N _____							
ppd ____yrs _____							
PRP Y/N _____							
All _____							
Meds _____							
_____							

PATIENT'S IDENTIFICATION (*Use this space for Mechanical nprint*)

<b>RECORDS MAINTAINED AT:</b> 		
PATIENT'S NAME ( <i>Last, First, Middle Initial</i> )		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

